State of California
Office of Administrative Law

In re:
Department of Managed Health Care

Regulatory Action:

Title 28, California Code of Regulations

Adopt sections: 1300.63.4
Amend sections:
Repeal sections:

NOTICE OF FILING AND PRINTING ONLY OF EMERGENCY REGULATION(S) OR ORDER(S) OF REPEAL

Government Code Section 11343.8

OAL Matter Number: 2021-0115-01

OAL Matter Type: Emergency File and Print Only (EFP)

The Department of Managed Health Care submitted this emergency action to adopt a regulation that implements Health and Safety Code section 1363.04, which requires the department to develop a uniform benefits and coverage disclosure matrix that must be used by health care service plans that issue, sell, renew, or offer a contract that covers dental services.

OAL filed this emergency regulation with the Secretary of State and will publish the emergency regulation in the California Code of Regulations.

This emergency regulatory action is effective on January 25, 2021 and, pursuant to Health and Safety Code section 1363.04(f)(2) and Executive Orders N-40-20 and N-71-20, will expire on September 25, 2021. The Certificate of Compliance for this action is due no later than September 24, 2021.

Date: January 25, 2021

Richard L. Smith
Richard L. Smith
Senior Attorney

For: Kenneth J. Pogue
Director

Original: Shelley Rouillard, Director
Copy: Fabiola Murillo

STATE OF CALIFORNIA—OFFICE OF ADMINISTRAT

EMERGENCY

NOTICE PUBLICATION/REGULATIONS SUBMISSION

STD. 400 (REV. 10/2019)

For use by Secretary of State only

OAL FILE NUMBERS	NOTICE FILE NUMBER	REGULATORY ACTION NUMBER	EMERGENCY NUMBER
	Z-		2021-0115-01EFP

For use by Office of Administrative Law (OAL) only

2021 JAN 15 A 9:30

OFFICE OF ADMINISTRATIVE LAW

NOTICE | REGULATIONS

ENDORSED - FILED
in the office of the Secretary of State
of the State of California
JAN 25 2021
1:28 pm

AGENCY WITH RULEMAKING AUTHORITY: Department of Managed Health Care

AGENCY FILE NUMBER (If any): Control No. 2020-DEN

A. PUBLICATION OF NOTICE (Complete for publication in Notice Register)

1. SUBJECT OF NOTICE	TITLE(S)	FIRST SECTION AFFECTED	2. REQUESTED PUBLICATION DATE

3. NOTICE TYPE	4. AGENCY CONTACT PERSON	TELEPHONE NUMBER	FAX NUMBER (Optional)
☐ Notice re Proposed Regulatory Action ☐ Other			

OAL USE ONLY	ACTION ON PROPOSED NOTICE	NOTICE REGISTER NUMBER	PUBLICATION DATE
	☐ Approved as Submitted ☐ Approved as Modified ☐ Disapproved/ Withdrawn		

B. SUBMISSION OF REGULATIONS (Complete when submitting regulations)

1a. SUBJECT OF REGULATION(S): Summary of Dental Benefits and Coverage Disclosure Matrix

1b. ALL PREVIOUS RELATED OAL REGULATORY ACTION NUMBER(S):

2. SPECIFY CALIFORNIA CODE OF REGULATIONS TITLE(S) AND SECTION(S) **(Including title 26, if toxics related)**

SECTION(S) AFFECTED (List all section number(s) individually. Attach additional sheet if needed.)

ADOPT: section 1300.63.4

AMEND:

TITLE(S): 28

REPEAL:

3. TYPE OF FILING

- ☐ Regular Rulemaking (Gov. Code §11346)
- ☐ Resubmittal of disapproved or withdrawn nonemergency filing (Gov. Code §§11349.3, 11349.4)
- ☒ Emergency (Gov. Code, §11346.1(b))
- ☐ Certificate of Compliance: The agency officer named below certifies that this agency complied with the provisions of Gov. Code §§11346.2-11347.3 either before the emergency regulation was adopted or within the time period required by statute.
- ☐ Resubmittal of disapproved or withdrawn emergency filing (Gov. Code, §11346.1)
- ☐ Emergency Readopt (Gov. Code, §11346.1(h))
- ☒ File & Print
- ☐ Print Only
- ☐ Changes Without Regulatory Effect (Cal. Code Regs., title 1, §100)
- ☒ Other (Specify) Health & Saf. Code section 1363.04(f)(2)

per agency request

4. ALL BEGINNING AND ENDING DATES OF AVAILABILITY OF MODIFIED REGULATIONS AND/OR MATERIAL ADDED TO THE RULEMAKING FILE (Cal. Code Regs. title 1, §44 and Gov. Code §11347.1)

per agency request

5. EFFECTIVE DATE OF CHANGES (Gov. Code, §§ 11343.4, 11346.1(d); Cal. Code Regs., title 1, §100)

- ☐ Effective January 1, April 1, July 1, or October 1 (Gov. Code §11343.4(a))
- ☒ Effective on filing with Secretary of State
- ☐ §100 Changes Without Regulatory Effect
- ☐ Effective other (Specify)

6. CHECK IF THESE REGULATIONS REQUIRE NOTICE TO, OR REVIEW, CONSULTATION, APPROVAL OR CONCURRENCE BY, ANOTHER AGENCY OR ENTITY

- ☐ Department of Finance (Form STD. 399) (SAM §6660)
- ☐ Fair Political Practices Commission
- ☐ State Fire Marshal
- ☒ Other (Specify) Department of Insurance

7. CONTACT PERSON	TELEPHONE NUMBER	FAX NUMBER (Optional)	E-MAIL ADDRESS (Optional)
Fabiola Murillo	916-255-2395		Fabiola.Murillo@dmhc.ca.gov

8. I certify that the attached copy of the regulation(s) is a true and correct copy of the regulation(s) identified on this form, that the information specified on this form is true and correct, and that I am the head of the agency taking this action, or a designee of the head of the agency, and am authorized to make this certification.

SIGNATURE OF AGENCY HEAD OR DESIGNEE	DATE
Mary Watanabe Digitally signed by Mary Watanabe Date: 2021.01.14 12:22:09 -08'00'	1/14/2021

TYPED NAME AND TITLE OF SIGNATORY: Mary Watanabe, Director

For use by Office of Administrative Law (OAL) only

AUTHORIZED FOR FILING AND PRINTING

JAN 25 2021

Office of Administrative Law

Proposed text noted by underline

§1300.63.4 Summary of Dental Benefits and Coverage Disclosure Matrix.

(a) Applicability

(1) This section shall apply to health care service plans or specialized health care service plans, issuing, selling, renewing, or offering a contract that covers the provision of dental services.

(2) This section shall not apply to any health care service plan contract for medical, surgical, and hospital services that offers dental services as a dental benefit within the medical, surgical, and hospital services contract.

(b) For purposes of this section only, the following definitions apply:

(1) "Group Contractholder" has the same meaning as in title 28, California Code of Regulations, section 1300.65(a)(6).

(2) "Plan" means a health care service plan or a specialized health care service plan, including its solicitors and representatives, that issues, sells, renews, or offers a contract that covers dental services.

(3) "Plan year" means a calendar year or a period of time as designated in the contract between the individual or group and the plan offering dental benefits.

(c) Summary of Dental Benefits and Disclosure Matrix Filing Requirements

(1) A plan subject to this section shall use the Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC), DMHC 10-278, dated 12/20, as incorporated herein by reference, and published by the Department on its website: www.dmhc.ca.gov. The plan shall use the SDBC for each dental product it issues, sells, renews, or offers. The plan's SDBC shall comply with the Instruction Guide for Summary of Dental Benefits and Coverage Disclosure Matrix, DMHC 10-277, dated 12/20, as incorporated herein by reference, and published by the Department on its website: www.dmhc.ca.gov.

(2) A plan shall use only a SDBC that reflects benefits including cost-sharing, exclusion, and limitation provisions the Department approved pursuant to Health and Safety Code section 1351 and Health and Safety Code section 1352 and implementing regulations.

(3) Within 15 months of the effective date of this section consistent with Health and Safety Code section 1363.04(a), the plan shall file an electronic affirmation with the Department stating its SDBCs comply with the provisions of this section for each Department-approved dental product it issues, sells, renews, or offers.

(4) As part of a plan's initial license application filed pursuant to Health and Safety Code section 1351, a plan shall file a SDBC with the Department that reflects benefits, including cost-sharing, exclusion, and limitation provisions, for each dental product it intends to issue, sell, or offer.

(5) After licensure, a plan shall file a SDBC for each dental product it proposes to add or amend in accordance with Health and Safety Code section 1352 in the following instances:

(A) When proposing a new dental product, the plan shall file a SDBC reflecting the proposed benefits, including cost-sharing, exclusion, and limitation provisions;

(B) When requesting an amendment to a previously approved SDBC, the plan shall file a SDBC reflecting the amended benefits including cost-sharing, exclusion, and limitation provisions; and

(C) When proposing an amendment to an SDBC for which it affirmed compliance in accordance with subdivision (c)(3), the plan shall file a SDBC reflecting the proposed benefits including cost-sharing, exclusion, and limitation provisions.

(d) Requirements for providing the Summary of Dental Benefits and Coverage Disclosure Matrix to Prospective or Current Enrollees for Individual and Group Coverage.

(1) Individual Coverage. All plans subject to this section shall provide in the following manner a SDBC for each dental product offered in the individual market:

(A) For prospective individual enrollment.

1. When presenting any dental product contract for examination or sale to a prospective individual enrollee, the plan shall provide the individual an applicable SDBC for each dental product for which the individual is eligible at the same time it provides other disclosure materials, including the Evidence of Coverage.

2. When requested, a plan shall provide a SDBC for each applicable dental product for which the prospective individual enrollee is eligible, including any other disclosure materials the plan is required to provide, within 7 business days following the request.

(B) For individual applications for dental coverage.

1. Within 7 business days following receipt of the application for coverage, the plan shall provide the individual prospective enrollee with the applicable SDBC and any other disclosure materials the plan is required to provide.

2. If the plan provided an applicable SDBC to the prospective individual enrollee before the individual applied for coverage, the plan shall be in compliance with (d)(1)(B)1. if the applicable SDBC the plan provided to the individual does not differ from the plan's applicable SDBC in effect at the time of application. If the plan's applicable SDBC in effect at the time of application differs from the SDBC the plan provided to the individual, the plan must provide the current applicable SDBC to the individual within 7 business days following receipt of the application but no later than the first day of coverage.

(C) Changes to the SDBC. If the plan's applicable SDBC in effect between the date of application and the first day of coverage differs from the SDBC the plan provided to the individual prospective enrollee pursuant to (d)(1)(B)1., the plan shall provide the current applicable SDBC to the individual no later than the first day of coverage.

(D) Renewal or reenrollment of dental coverage. The SDBC shall be provided no later than the date on which the coverage application and other disclosure

materials are distributed. If renewal occurs automatically, the SDBC shall be provided no later than 30 days before the beginning of the plan year.

(E) Method of Delivery. Plans shall provide the SDBC in one or more of the following ways:

1. In paper form, free of charge, and delivered to the individual's mailing address.
2. Electronically by email. The plan shall notify the enrollee a paper copy is available free of charge and inform the enrollee how to contact the plan for a paper copy or with questions.
3. If provided on the plan's website, the plan shall:
    a. Place the SDBC in a location on the plan's website that is prominent and easy to access;
    b. Ensure the SDBC allows for electronic retention, such as saving and printing;
    c. Ensure the SDBC is accessible to individuals living with disabilities in accordance with applicable federal and state law; and
    d. Notify the group that a paper copy is available free of charge and inform the enrollee how to contact the plan for a paper copy or with any questions.

(2) Group Contracts. A plan subject to this section offering group coverage shall provide a SDBC for each dental product it offers in the group market in the following manner:

(A) Delivery of SDBC. When a group contracts for coverage, the plan shall provide the applicable SDBCs to the group upon delivery of the completed health care service plan contract. The SDBC shall be provided at the same time the plan provides other disclosure materials, including the applicable Evidence of Coverage.

(B) Changes to the SDBC. If the plan's applicable SDBC in effect between the date the group signs contract for coverage and the group's first day of coverage differs from the SDBC the plan provided to the group pursuant to (d)(2)(A), the plan shall provide the updated applicable SDBC to the group no later than the first day of coverage.

(C) Renewal or reenrollment of dental coverage. The plan shall provide the SDBC no later than the date on which other disclosure materials including the Evidence of Coverage are distributed. If renewal occurs automatically, the SDBC shall be provided no later than 30 days before the first day of the plan year.

(D) Method of Delivery. Plans shall provide the SDBC in one or more of the following ways.

1. In paper form free of charge and delivered to the group's mailing address.
2. Electronically by email. The plan shall notify the group a paper copy is available free of charge and inform the group how to contact the plan for paper copy or with any questions.
3. If provided on the plan's website, the plan shall:

a. Place the SDBC in a location on the plan's website that is prominent and easy to access;
b. Ensure the SDBC allows for electronic retention, such as saving and printing;
c. Ensure the SDBC is accessible to individuals living with disabilities in accordance with state and federal requirements; and
d. Notify the group a paper copy is available free of charge and inform the group how to contact the plan for paper copy or with any questions.

(3) Group Contractholder Obligations.

(A) Prior to enrollment. When offering coverage to eligible subscribers, the group contractholder shall provide an applicable SDBC for each dental product it is offering to each person eligible to be a subscriber under the group contract at the same time the group contractholder provides other disclosure materials.

(B) Upon application for dental coverage. The SDBC shall be provided by the group contractholder to each subscriber as part of any written application materials that are distributed for enrollment at the time the application materials are distributed.

1. The SDBC and any other required disclosure materials shall be provided to the subscriber by the group contractholder within 7 business days following receipt of the application for coverage.
2. If the group contractholder provided an applicable SDBC to the subscriber prior to the subscriber applying for coverage, the group contractholder shall be in compliance with (d)(3)(B)1. if the SDBC the group contractholder provided to the subscriber does not differ from the applicable SDBC in effect at the time of application. If the SDBC the group contractholder provided to the subscriber differs from the applicable SDBC in effect at the time of application, the group contractholder shall provide the current SDBC to the subscriber within 7 business days after receipt of the application but no later than the first day of coverage.

(C) Changes to the SDBC. If the applicable SDBC in effect between the date of application and the first day of coverage differs from the SDBC the group contractholder provided to the subscriber pursuant to (d)(3)(B)1., the group contractholder shall provide the current applicable SDBC to the subscriber no later than the first day of coverage.

(D) Upon renewal or reenrollment of dental coverage. The SDBC shall be provided no later than the date on which the coverage application and other disclosure materials are distributed. If renewal occurs automatically, the SDBC shall be provided no later than 30 days prior to the first day of the plan year.

(E) Method of Delivery. Group contractholders shall provide the SDBC in one or more of the following ways:

1. In paper form, free of charge, and delivered to the individual's mailing address.
2. Electronically by email. The contractholder shall notify the subscriber that a paper copy is available free of charge and shall provide information on how to contact the plan for a paper copy or with any questions.
3. Direct the subscriber to the plan's website for a copy of the SDBC.

(e) Special Enrollment. A plan shall provide the SDBC to enrollees qualifying for coverage under special enrollment periods at the same time it provides other disclosure information, including the Evidence of Coverage.

(f) When requested by an enrollee, regardless of whether the enrollee is enrolled in individual or group coverage, the plan shall provide the applicable SDBC within 7 business days of the request by the methods described in (d)(1)(E).

(g) The plan shall ensure all group contractholders comply with the requirements of this section.

(h) If a plan delegates any of the requirements under this section to another entity, the plan remains responsible for ensuring its delegate or delegates complies with the provisions of this section.

(i) The SDBC provided pursuant to this section shall comply with the requirements of Health and Safety Code section 1367.04 and Title 28, California Code of Regulations section 1300.67.04.

(j) Failure to comply with the requirements of this regulation may constitute a basis for disciplinary action against the health plan. The Director shall have the civil, criminal, and administrative remedies available under the Knox-Keene Act, including section 1394.

Note: Authority cited: Section 1344 and Section 1363.04, Health and Safety Code.
Reference: Section 1363.04, Health and Safety Code.

State of California
Health and Human Services Agency
Department of Managed Health Care
INSTRUCTION GUIDE FOR SUMMARY OF DENTAL BENEFITS AND COVERAGE DISCLOSURE MATRIX
DMHC 10-277 New: 12/20

DEPARTMENT OF Managed Health Care

Instruction Guide for Summary of Dental Benefits and Coverage Disclosure Matrix

INSTRUCTIONS AND FORMATTING FOR THE ENTIRE SUMMARY OF DENTAL BENEFITS AND COVERAGE DISCLOSURE MATRIX

A. The Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC) must be a stand-alone document that is not incorporated into any other document.
B. Do not alter or remove existing formatting or language unless otherwise specified in this instruction guide.
C. Plans shall use Arial 12-point font.
D. Prior to distribution of the matrix, remove text that is bracketed and in red font.

Part I: GENERAL INFORMATION

A. Insert plan and product specific information in this section and replace red bracket text, as directed.
B. "Name of Product" may be the Plan's product identifier.
C. Effective Date: Use the following format to report the applicable beginning and end dates for the plan or year: XX/XX/XXXX- XX/XX/XXXX. If the end date for the coverage period is not known, insert: Beginning on or after XX/XX/XXXX.
D. The phone number listed in the header shall be the plan's customer service phone number for consumers.

Part II: DEDUCTIBLE

A. Report the in-network and out-of-network deductibles here. If there is no deductible, state "none" in the table. If there are different deductibles for "Individual" and "Family," include both.
B. Under the Deductibles table, use the template language to report the services to which the deductible applies. For brevity, this may be a summary statement, noting exceptions.

Part III: MAXIMUMS

A. Report the applicable maximums, as directed in the Maximum Table.
B. For "Out-of-Network," select one of the three choices: (1) [Yes, the cost-sharing will be higher. Contact your Plan]; (2) [No]; or (3) [Not applicable]. If the choice selected is "Yes" include the additional text into the SDBC.

Part IV: WAITING PERIODS

A. Report all waiting periods applicable to the product here, including the length of the waiting period(s) and the service(s) to which they apply. If there are no waiting periods, include a statement to that effect.

Part V: WHAT YOU WILL PAY

A. Dental procedures listed below, and in the first column of the "WHAT YOU WILL PAY" table, may not be altered in any way. For purposes of the SDBC, the following procedures are defined as follows:
    i. Oral Exam: comprehensive oral evaluation – new or established patient

ii. Bitewing X-ray: single radiographic image
iii. Cleaning: prophylaxis – adult
iv. Filling: resin based composite – one surface, anterior
v. Simple Extraction: extraction, erupted tooth or exposed root (elevation and/or forceps removal)
vi. Root Canal: endodontic therapy, molar tooth (excluding final restoration)
vii. Scaling and Root Planing: periodontal scaling and root planing – four or more teeth per quadrant
viii. Ceramic Crown: porcelain/ceramic
ix. Removable Partial Denture: maxillary partial denture – cast metal framework resin denture bases (including any conventional clasps, rests and teeth)
x. 3 Unit Bridge: pontic and retainer crown – porcelain fused to high noble metal

B. Include in the Category column one of the following descriptions: Preventive & Diagnostic; Basic; or Major as applicable to each service.
C. In the In-Network and Out-of-Network columns include the copayment or coinsurance applicable for each service.
D. For any service in the SDBC not covered by the product, state "Not Covered" in the In-Network and/or Out-of-Network columns, as applicable.
E. Benefit Limitations and Exclusions Column: In this column, list the following, if applicable:
   i. Limits on the frequency of the service (E.g. one per year).
   ii. Waiting periods.
   iii. If cost sharing is different when the service is performed by a specialist (as compared to a general dentist), make a note and include that amount or percentage.
   iv. If the service will be covered only if performed by a general dentist.
   v. A cross reference to the disclosure document(s) where the full limitations and exclusions for the product can be found.

Part VI: COVERAGE EXAMPLES

A. The "Total Cost of Care" amount populated in the table is for illustrative purposes and may not be altered.
B. Fill in the deductible, annual maximum, copayment/coinsurance and cost for service using information applicable to the specific product referenced in the header.
C. Report the information for in-network and out-of-network where the form indicates. Except for as directed in Part VI., E., below, when services are not covered out of network, report "not covered" next to "Out-of-network."
D. If the deductible does not apply to the service(s), report "Not Applicable" in the associated box.
E. The "In this example, [enrollee] would pay" row shall include the hypothetical cost share the enrollee would be responsible for, utilizing the provided cost of care. Include the deductible, if applicable, in the calculation. If the cost of the example itself would exceed the annual limit on its own, that should be reflected in the reported example cost. If the services are not covered out-of-network, this row shall reflect the full cost of the service next to "Out-of-network."
F. The "What is not covered or subject to a limitation" row shall include all items listed in these instructions under Part V., E., i.-iv.

State of California
Health and Human Services Agency
Department of Managed Health Care
SUMMARY OF DENTAL BENEFITS AND COVERAGE DISCLOSURE MATRIX (SDBC)
DMHC 10-278 New: 12/20

DEPARTMENT OF Managed Health Care

Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Plan Name:
Type of Product Line: [select one: DHMO, PPO]
Effective Date: [see Instruction Guide Part I., C.]

Name of Product:
Plan Phone #: [for consumers]
Plan Website:

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND WHAT YOU WILL PAY FOR COVERED SERVICES. THIS IS A SUMMARY ONLY AND DOES NOT INCLUDE THE PREMIUM COSTS OF THIS DENTAL BENEFITS PACKAGE. PLEASE CONSULT YOUR EVIDENCE OF COVERAGE AND DENTAL CONTRACT FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS. FOR MORE INFORMATION ABOUT YOUR COVERAGE, VISIT THE PLAN WEBSITE [insert Plan website] **OR CALL** [insert Plan phone number].

THIS MATRIX IS NOT A GUARANTEE OF EXPENSES OR PAYMENT.

Part II: DEDUCTIBLES

Deductible	In-Network	Out-of-Network
Dental	[indicate whether "per individual or "per family" and enter $ amount]	[indicate whether "per individual or "per family" and enter $ amount]

- **[The deductible applies to all services / all services except [list exceptions here] / the following services [list services here].] OR [There is no deductible.]**
- A **deductible** is the amount you are required to pay for covered dental services each plan year before the plan begins to pay for the cost of covered dental treatment.
- **In-network services** are dental care services provided by dentists or other licensed dental care providers that contract with your plan to provide dental services.

- **Out-of-network services** are dental care services provided by dentists or other licensed dental care providers that are not contracted with your plan.

Part III: MAXIMUMS PLAN WILL PAY

Maximums	In-Network	Out-of-Network
Annual Maximum	[enter $ amount]	[Indicate [Yes, the cost-sharing will be higher. Contact your Plan.], [No], or [Not applicable]]
Lifetime Maximum for Orthodontia	[enter $ amount]	[enter $ amount]

- **Annual maximum** is the maximum dollar amount your plan will pay toward the cost of dental care within a specific period of time, usually a consecutive 12-month or calendar year period.
- **Lifetime maximum** means the maximum dollar amount your plan providing dental benefits will pay for the life of the enrollee. Lifetime maximums usually apply to specific services, such as orthodontic treatment.

Part IV: WAITING PERIODS

Waiting Periods: A waiting period is the amount of time that must pass before you are eligible to receive benefits or services for all or certain dental treatments. **Your dental benefit package [Describe waiting period or indicate there is no waiting period.]**

Part V: WHAT YOU WILL PAY

All copayments and coinsurance costs shown in this chart apply after your deductible has been met, if a deductible applies. The Common Dental Procedures fit into one of the following applicable categories: Preventive & Diagnostic, Basic or Major. The Benefit Limitations and Exclusions column includes common limitations and exclusions only. For a full list, see the full disclosure document referenced in the Benefit Limitations and Exclusions column.

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions
Oral Exam	[Category]	[Enter % or $ amount]	[Enter % or $ amount]	[List as applicable]
Bitewing X-ray	[Category]	[Enter % or $ amount]	[Enter % or $ amount]	[List as applicable]

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions
Cleaning	[Category]	[Enter % or $ amount]	[Enter % or $ amount]	[List as applicable]
Filling	[Category]	[Enter % or $ amount]	[Enter % or $ amount]	[List as applicable]
Simple Extraction	[Category]	[Enter % or $ amount]	[Enter % or $ amount]	[List as applicable]
Root Canal	[Category]	[Enter % or $ amount]	[Enter % or $ amount]	[List as applicable]
Scaling and Root Planing	[Category]	[Enter % or $ amount]	[Enter % or $ amount]	[List as applicable]
Ceramic Crown	[Category]	[Enter % or $ amount]	[Enter % or $ amount]	[List as applicable]
Removable Partial Denture	[Category]	[Enter % or $ amount]	[Enter % or $ amount]	[List as applicable]
3 Unit Bridge	[Category]	[Enter % or $ amount]	[Enter % or $ amount]	[List as applicable]
Orthodontia	Orthodontia	[Enter % or $ amount]	[Enter % or $ amount]	[List as applicable]

Part VI: COVERAGE EXAMPLES

THESE EXAMPLES DO NOT REPRESENT A COST ESTIMATOR OR GUARANTEE OF PAYMENT. The examples provided represent commonly used services in the categories of Diagnostic and Preventive, Basic and Major Services for illustrative purposes and to compare this product to other dental products you may be considering. Your actual costs will likely be different from those shown in the chart below depending on the actual care you receive, the prices your providers charge and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and the summary of excluded services under the plan.

Dana Has a Dental Appointment with a New Dentist	**Sam Needs a Tooth Filled**	**Maria Needs a Crown**
New patient exam, x-rays (FMX) and cleaning	Resin-based composite – one surface, posterior	Crown – porcelain/ceramic substrate

Dana's Visit	**Dana's Cost**	**Sam's Visit**	**Sam's Cost**	**Maria's Visit**	**Maria's Cost**
Total Cost of Care	In-network: $250 Out-of-network: $450	Total Cost of Care	In-network: $150 Out-of-network: $250	Total Cost of Care	In-network: $950 Out-of-network: $1,400
Deductible	In-network: [Enter $ amount] Out-of-network: [Enter $ amount]	Deductible	In-network: [Enter $ amount] Out-of-network: [Enter $ amount]	Deductible	In-network: [Enter $ amount] Out-of-network: [Enter $ amount]
Annual Maximum (Plan Will Pay)	In-network: [Enter $ amount] Out-of-network: Indicate [Yes, the cost-sharing will be higher. Contact your Plan.], [No], or [Not applicable]]	Annual Maximum (Plan Will Pay)	In-network: [Enter $ amount] Out-of-network: Indicate [Yes, the cost-sharing will be higher. Contact your Plan.], [No], or [Not applicable]	Annual Maximum (Plan Will Pay)	In-network: [Enter $ amount] Out-of-network: Indicate [Yes, the cost-sharing will be higher. Contact your Plan.], [No], or [Not applicable]

Dana's Visit	**Dana's Cost**	**Sam's Visit**	**Sam's Cost**	**Maria's Visit**	**Maria's Cost**
Patient Cost (copayment or coinsurance)	In-network: [Enter % or $ amount] Out-of-network: [Enter % or $ amount]	Patient Cost (copayment or coinsurance)	In-network: [Enter % or $ amount] Out-of-network: [Enter % or $ amount]	Patient Cost (copayment or coinsurance)	In-network: [Enter % or $ amount] Out-of-network: [Enter % or $ amount]
In this example, Dana would pay (includes copays/coinsurance and deductible, if applicable):	**In-network:** [Enter $ amount] **Out-of-network:** [Enter $ amount]	**In this example, Sam would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network:** [Enter $ amount] **Out-of-network:** [Enter $ amount]	**In this example, Maria would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network:** [Enter $ amount] **Out-of-network:** [Enter $ amount]
Summary of what is not covered or subject to a limitation:	[List as applicable]	Summary of what is not covered or subject to a limitation:	[List as applicable]	Summary of what is not covered or subject to a limitation:	[List as applicable]